DOCUMENT RESUME

ED 077 573 PS 006 499

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| AUTHOR | Harper, Randolph T.; And Others |
| TITLE | Treating the Mother-Child Dyad in the Nursery School. |
| INSTITUTION | Louisiana State Univ. Medical Center, New Orleans. |
| PUB DATE | Nov 72 |
| NOTE | 18p.; Paper presented at the annual meeting of the American Association of Psychiatric Services for Children (Washington, D.C., November 1-5, 1972) |
| EDRS PRICE | MF-$0.65 HC-$3.29 |
| DESCRIPTORS | *Child Development Centers; *Child Psychology; *Mother Attitudes; *Nursery Schools; Parent Child Relationship; *Parent Education; Preschool Education; Psychotherapy; Speeches |

ABSTRACT

A preliminary report is provided on a therapeutic nursery school program at Louisiana State University Medical Center in New Orleans. The program emphasizes the mother-child unit rather than the child as a single individual. Within the mother-child relationship, attention is given to altering perceptions and expectations, to experience of and sharing of affect, and to the development of new behaviors and practices. Long- and short-term treatment goals are set for each mother-child unit. There are therapist-educators for the children and educators for the mothers. Examples of the treatment process are provided. (DB)

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# TREATING THE MOTHER-CHILD DYAD IN THE NURSERY SCHOOL

by

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A paper presented at the annual meeting of The American Association of Psychiatric Services for Children, November 1-5, 1972. Washington Hilton, Washington, D.C.

PS 006499

This afternoon we would like to present a preliminary report on a therapeutic nursery school program at Louisiana State University Medical Center in New Orleans. The program is new and experimental, and we welcome the opportunity to share our ideas, rationale, and initial impressions of the program with you. Because of limitations in time we will forego any review of the literature relating to therapeutic work with the emotionally disturbed preschool child and simply acknowledge at this point that we are significantly indebted to the work of many predecessors and contemporaries in the development of our program.

Our program has a particular bias and emphasis. We have chosen to devote most of our energies to the mother-child unit rather than to the child as a single individual. Thus we have the commitment of mother to stay with her child in school full time for as long as we consider necessary.

We have made a central assumption that we can intervene more effectively if we concentrate on the mother-child dyad. We have further assumed that in this way change can be induced more rapidly, maintained more effectively, and have a greater probability of generalization to other situations. We have also assumed that whether or not difficulties in the mother-child relationship are central causative factors, these difficulties do tend to maintain, perpetuate, and indeed intensify in ways which are clearly counter to healthy development. We do not ignore the individual needs of mother and child, or other important relationships such as father-mother (husband-wife), father-child, and sibling.

Within the mother-child relationship we have emphasized the altering of perceptions and expectations; the experience of and sharing of affect, and the development of new behaviors and practices.

The school is staffed by two full time teacher-therapists, two part time social workers, and several consultants. One consultant, a clinical psychologist, functions as the program director; conducts admission, treatment planning, and disposition conferences, meets with the staff for process consultation and, in conjunction with a social worker, conducts a weekly parents' group. A second consultant, a child psychoanalyst, meets with the teachers for individual case consultations. A pediatric neurologist is also a consulting member of the team.

Our work with both parents outside of the school setting proper varies from a problem-centered and reality-based focus upon their roles as parents and spouses to some work involving a more psychotherapeutic focus on the couple or individual. Each mother and father couple also meets with one of the social workers who deal with interpretive and entry problems and then follow a case work model with each set of parents on a continuing basis.

After a diagnostic evaluation, the initial days of a child's entry to the school concentrate on helping the mother and child adapt to the new setting, gathering further data on the child's level of development, and establishing baseline data with respect to the mother-child interaction and the child's individual behavior in the school setting. With this information available, long and short term treatment goals are set for each mother-child unit.

The teachers work at facilitating the attainment of these goals in a variety of ways. They are therapist-educators for the children. They function as role models for the mothers, demonstrating more appropriate and effective modes of responding to the children. The teachers serve as emotional supporters of mothers and attempt to help them achieve a more mature level of functioning. They are educators for the mothers, providing them with information on child rearing.

Our mothers also have multiple roles. Primary among these is as mother

to their own child, functioning as care taker, teacher, disciplinarian, adult playmate, and a resource of love, support and guidance. Mothers sometimes later provide some of the same functions for the other children, moving somewhat into the role of teacher. In a sense, the mother is also sometimes a child, i.e., when she is being advised, supported, "taught" by others. Indeed, two mothers have spontaneously referred to the teachers as Grandmothers. Mother is also a colleague. The mothers have formed a cohesive peer group, giving each other support, demonstrating considerable emotional investment in and concern for each other, and developing a help-giving role for themselves.

As part of our treatment design we attempt to provide a permissive environment in which we don't make deep interpretations but rather ones that help the child get in touch with and be able to recognize his feelings and needs, to express and manage these in constructive ways, and to develop more adequate ego controls. We attempt to help the child develop trust and object relations utilizing his own mother and the therapeutic teacher. The mother is involved in the treatment process, lending herself to her child for re-experiencing the missed and distorted developmental phases.

We would now like to relate a few examples of our work.

In June, 1970, 4 year old Maryann was brought to the clinic by her mother who was particularly anxious about slow speech development. Lesser concerns of the parents were lack of bowel training and temper tantrums.

Maryann's birth was reportedly normal and uncomplicated. The pregnancy was unplanned, and delivery occured during a time when the father was out of work. Mrs. E. was depressed for about two weeks after the delivery. Maryann was breast fed for 6 to 8 weeks and was described as a quiet baby and a good eater. At 10 months she said some words and was walking at 14 months. At 18 months a beloved young aunt died and soon after Maryann seemed to abandon her attempts at speech. When Maryann was 3 years old, and placed in a day nursery, her little brother was born.

Early toilet training was not successful, was abandoned, then begun again. The parents believed that for Maryann a daily bowel movement was essential and were determined to arrange it by any means. Both mother and father were involved in this process which included the use of enemas, laxatives and suppositories, and sometimes digital removal of the feces.

We were impressed that Maryann's person, both psychological and physical, had been very significantly invaded and violated, and that she and mother had a destructive symbiotic relationship. There were significant disturbances in body image, object relationships, ego controls and level of mental and emotional development.

When Maryann and her mother began attending the Therapeutic Nursery School, Maryann was a pale child with thin legs, blonde hair, and blue eyes which were rimmed with dark circles. Her features were usually contorted. Her movements were clumsy, and she frequently bumped into chairs and equipment but never acknowledged hurts. Mother ignored these injuries. Though Maryann experienced some terribly hard falls, her body rarely responded by bruising.

Her frequent vocalizations usually consisted of unintelligible sounds. Her vocabulary was limited to the word "ma" to identify all the adults in school, "go" to express any sort of dissatisfaction, and "yay" when she seemed pleased or happy. Mother frequently requested speech from her, telling her to repeat mannerly statements and apologies.

Maryann moved quickly about the nursery school room, scooping up arm loads of books and slamming them on the table, clearing the block and toy shelf by throwing the contents on the floor, pouring water haphazardly in the kitchen corner, and walking around the room with her arms overflowing with pieces of equipment. During this constant motion, mother followed in her wake, chattering incessantly about the things Maryann shouldn't be doing and giving complicated instructions, all of which Maryann ignored. Mother's anger was always near the surface, and she often yelled out or held Maryann's arm in a vise-like grip. Maryann was frequently frustrated and angry and expressed her anger by beating her head or chest with her fist while moaning or crying. One of the main sources of contention between them was the quantity of toys used--mother forever limiting and trying to pull away, daughter collecting and desperately holding on. On walks around the school grounds Maryann's only interest was in collecting and holding rocks. Indoors she spent a great deal of time dancing in front of the mirror and making bizarre gestures at her image. She could not tolerate juice time nor lunch time and while the others were at the table, she unhappily wandered the room.

Maryann was being given Ritalin as prescribed by her pediatrician. We decided to work without the drug and, with the approval of the pediatrician, its use was discontinued. This seemed to have an immediate calming effect on her.

It seemed appropriate to assign one teacher to Maryann herself as part of our plan to give her "enough" and to provide constant support, particularly at eating times when she refused to come to the table. Goals of her treatment included increasing her self-awareness and helping her develop loving and trusting relationships.

Mrs. E. was at the social-emotional level of about an 8 year old when she and Maryann started school. In addition to her high pitched, little girl voice and her constant competing with Maryann for teacher's attention, Mrs. E. reported that she was a regular watcher of Captain Kangaroo on television, even though the children meanwhile might be wrecking the house. She brought gifts for school, such as holiday decorations, and was not able to share with her daughter the pleasure of handing them to teacher. But her miserliness was most apparent as she described the "bargain" clothes she bought for herself and her family.

Through our constant attention to the mother's needs and our support and approval of her newly developing skills with her daughter, Mrs. E. seemed to speed up her maturation so that by the end of the first year she was functioning more at an adolescent level. Now after two years she is in many ways a competent young adult. She has worked through some of her depression and rage related to her own early affective deprivation. Further, she has been able to apply her new expertise in raising the younger sibling more appropriately.

Many changes have been effected between mother and child. Mrs. E. learned to allow Maryann the privacy of her body and her toilet routines. She has accepted Maryann's need to collect and possess many toys and objects. Maryann was even given a special shelf at home for the rocks she gathered. Her hoarding impulses were sometimes sublimated into making "rock pictures". Mother gave up her demands for speech, and within the past few months Maryann's speech development has suddenly blossomed. Most important, a positive, loving relationship

between mother and child seems firmly established.

Maryann now is interested in numbers and letters, taking great pleasure in counting objects like play money and in watching teacher print the words she repeats for her.

Maryann is in the process of being transferred to a special education class in our Public Schools.

This case represented a rather severely emotionally disturbed child who was also at least functionally retarded. While firm progress was made, continuing therapeutic and educations efforts are clearly indicated.

When Wendy was referred by her pediatrician to the Therapeutic Nursery School shortly before her 3rd birthday, the presenting problems were lack of toilet training and refusing to chew or swallow any solid food.

Wendy was born out of wedlock. Little is known of her first 8 months except that she was cared for during the day by a neighbor while mother worked. From the meager amount of information gleaned about this early period, we know that Wendy did not take a bottle and that she was left to lie alone in her crib for long periods of time. At 8 months her mother gave her to her father's family because the mother was not able to support her. At this time Wendy weighed only 8 pounds, was nearly bald and had severe diaper rash which covered almost her entire body, indicating gross neglect. Mrs. H., Wendy's grandmother, patiently and painstakingly nursed her back to health. This difficult task was complicated by the fact that Wendy refused for many months to accept a bottle.

When Wendy began school, she was accompanied by her grandmother. Wendy presented as an attractive but skinny child who seemed small for her 3 years. She was neatly and attractively dressed, with her hair carefully arranged. When she stood still, her head hung toward one side with a slight tremor. One eye sometimes wandered involuntarily. When teacher looked at her, she covered her eyes with her hand.

Wendy was not toilet trained. She ate only strained baby foods and before entering school had never fed herself. She said a few words clearly, including "Jane" (her aunt), "all gone," and "shit". She spent long periods of time at home and at school lying on the floor listlessly and barely moving a small car to and fro. She showed no interest in using other play materials.

Wendy's grandmother seemed to have unrealistic expectations of her. She often instructed Wendy to "act like a little lady" and seemed unable, at first, to allow her to progress at her own pace or to accept necessary and constructive regressions.

Mrs. H. needed particular help in the area of toilet training and found it difficult to accept the nursery school recommendations that she cease all scolding and punishing for soiling.

In school, Wendy was sponged and powdered like an infant when she wet, though she was also given the opportunity to participate in routine toilet times with the other children.

The grandmother's same controlling attitude was evident during meal time. Progress in these two areas was very slow. The opportunities to regress to an infant period were, for a long time, violently rejected by Wendy as she flung away a proffered bottle, and climbed in and rapidly out of the buggy or baby bed.

Our treatment plan for Wendy included permitting her as much as possible to control her environment. She alone decided when or whether to change her wet pants, and she initiated many "stop-go" games with teacher. We stayed close during her regressive play simply articulating her behavior, and responded to her reaching out--which eventually developed into her great demands for affectionate demonstrativeness. Gradually her aggression also began to emerge. (She did a lot of cursing, spitting and shoving.)

Slowly Wendy began to accept solid foods such as American cheese, soft scrambled eggs, then hard boiled eggs and other things. Toilet accidents still occur but now Wendy sometimes goes to the toilet on her own and usually toilets at routine times.

After 1½ years in school, Wendy has become an engaging child who enjoys the affection of her teachers. She is friendly in school and is the pet of her family and neighborhood. In language, Wendy has progressed from simply naming objects and repeating words to complex sentences. Though still needing much of the perseverative truck-pushing type of play (she sometimes licks the trucks as they pass her face), Wendy is nonetheless capable of puzzle working, pegboards and bead stringing, and enjoys picture books and music. In essence, Wendy has learned how to play.

When the aged grandmother found the daily trips by bus to school too trying, other members of the family participated in the program with Wendy. Thus the nursery school had the opportunity to work with Wendy's aunt and cousins, thereby providing a multiple impact on her home situation.

Plans now are for Wendy to transfer to an Urban League day care center nursery school in January. After one semester there among peers, we hope Wendy will be ready for kindergarten next September when she will be 5 years old.

Mickey C. was referred to the Clinic by a family doctor who considered it unusual for a child of 2½ not to talk. Mickey had never spoken but made frequent grunting sounds and occasionally whined. The parents reported that Mickey was clumsy. They also said "Mickey could amuse himself all day by playing with a door".

Mickey was born in December of 1968. His birth was reported normal. Mickey was not a planned child--the parents said none of their nine children were planned. Mickey was the 8th child and the 3rd boy. He sat between 6 and 9 months. The parents do not remember Mickey crawling but he walked at about 18 months.

Mickey was generally described as a good baby who played in his play pen and did not cry unless he was angry. The parents claimed they whipped him and threatened him about the boogy-man and yet he did not cry.

Mickey's parents said he did not seem to know them, and during the initial interview he showed them no affectional attachment. They said that Mickey will "go to anybody".

Mrs. C. was a very assertive, domineering woman who tended to monopolize the conversation. She identified Mickey with his father toward whom she openly expressed much hostility. Her role in the home was masculine in nature, and her capacity for warmth and understanding seemed limited.

Mr. C. was a small, passive-dependent individual whose alcoholism had prevented him from holding a job. The family survived on welfare and what free services Mrs. C. was able to elicit in the community.

In a number of ways Mr. C. also evidenced role confusion. He cooked and served the family meals, and played with and cared for the children. He appeared quite motivated and concerned about Mickey's treatment and brought Mickey for most of his appointments.

Mickey at 3½ was the first child admitted into the newly opened Therapeutic Nursery School in June 1970, after having been seen individually for 9 months. He was cute, short, small boned, with brown hair and eyes. He had no speech except ba-ba (for bye-bye). He had no eye contact; he was not toilet trained; he had never fed himself except with a bottle which he was still using; he had played with no toys in his home and amused himself there by rotating a coat hanger around a door knob and in his hands while going to sleep. Mickey entertained his siblings by running into the wall, slamming doors, throwing himself on the floor or down the stairs and laughing--generally playing the bafoon, often resulting in self injury. Mickey was a physical danger to his 15 month old sister who was kept safe from him in a play pen all day.

Mickey was considered wild and uncontrollable by his family. The siblings frequently requested that the parents tie him up.

Mickey showed no appropriate affect. He manipulated adults in his environment as tools or extensions of himself by pulling them to the desired object and directing their hand.

Mickey's 11 member family lived in a 2 bedroom, 1 bath project apartment. Home life was crowded and chaotic, with many violent episodes provoked by father's bouts of drunkenness.

Mr. C. beat Mickey's mother and siblings, and on occasion tried to breakdown the bedroom door they barricaded against him. When he was locked completely out of the house he used the fire escape to try to enter through windows. Once he set his bed on fire when he fell asleep smoking and was left there while the rest of the family stayed outdoors and laughed about who would be the one to rescue him. (This was all reported humorously by Mrs. C. to her social worker). Also in Mickey's presence, his mother

and the other children discussed Mr. C.'s possible drunken death at the wheel of the car.

On the day of his preliminary school visit, both parents arrived with him, with Mother clearly dominating. Mother talked to teachers while Father showed toys to Mickey and encouraged him to try everything out. Mickey followed all his leads. Father stayed close, encouraging, helping. Mother showed little interest except when Mickey got wet at the fountain.

We asked that Mother or Father come everyday with Mickey. Mother said that Father is "very unreliable", and Father did not argue. On Mickey's first full day in school, he threw most of the equipment that he used--without anger, direction, or obvious intent. Mickey generally seemed to shut out the outside world and walked around with half-closed eyes. During the first week he spent much time opening and closing the doors. He laughed frequently--at the balloons he popped by biting, at the silverware he dropped, at the pegboard screen he overturned, and at the water going full blast in the bathroom splashing wall and floor. When Mickey fell and got hard bumps on his head or bruises, he laughed his hardest.

Mrs. C.'s manner with Mickey was awkward and unloving. She constantly interfered with his activities--scolding, directing, threatening, and in between talking loudly to teachers and laughing raucously. For weeks she recounted a steady stream of catastrophes that daily hit various members of her immediate family, laughing during the telling. Mickey's father on the other hand on his days in school helped Mickey in play, kissed him and held him lovingly while talking with him softly. He was also able to tolerate periods of relative quiet and calm in the classroom.

Mrs. C. soon eased herself out of the chore of accompanying Mickey, and we were seeing Mr. C. more frequently. We noticed that Mickey's best days

were when Father was there. After re-evaluating Mickey's relationship with his Mother, we decided to insist on Mrs. C.'s daily attendance.

After this initial period of adjustment Mrs. C. stayed in school with Mickey every morning 3 hours a day, 15 hours a week for almost 6 months. A consultative program of speech therapy was begun after Mickey was in school 4 months.

We treated Mickey's denial of bodily hurts the same as we did Maryann's. We pointed out what part of him was injured and offered consolation or appropriate first aid. We also told him when he was feeling good, when he was having fun, etc., verbalizing the feelings he seemed to be experiencing.

In school over many months Mickey repetitively engaged in isolated play in which he reenacted events from his home life. We saw scenes of father falling drunkingly down the stairs (Mickey played this out on the slide); we saw the father doll trying to enter the house through the window, the chimney, or from the roof; we saw the family and furniture moved into and out of the house; Mickey drove the car right into the house, scattering the furniture and the people, and turned the house up side down, dumping everything. But he also played lengthy kissing scenes with the father and mother doll holding the little boy doll between them..

During his hours of isolated involvement in fantasy play, teacher sat close but not intruding--simply verbalizing what Mickey seemed to be doing. For months Mickey showed no awareness of her presence or her words. But one day, when teacher became silent, he touched her leg, indicating he wanted her to go on.

Later Mickey's play began to dramatize the activities of workmen around the school--reflecting his growing awareness and interest is his

external surroundings. From blocks he constructed a tractor and took everyone for a ride, as he had been taken by a friendly workman a few days before. With chairs he made a bus and arranged us all as passengers on it. After about a year in school, he began eye contact. Mickey was coming out of his cocoon.

Mrs. C. became softer, quieter, more capable of expressing warmth and tenderness toward Mickey, and quite sensitively attuned to his needs as she kept her eye on him throughout the morning and was appropriately available to him.

After the 1st 6 months, Mrs. C.'s required attendance was reduced to 2 mornings a week so we could keep in touch with the home situation and how Mickey was developing in school. We also used this time to demonstrate and explain any new expectations we had of Mickey and techniques for encouraging them. Mickey continued to grow--changing from a child who seemed to need no one in particular and could occupy himself alone for hours to one who could readily give and receive affection, who cried when his mother left the room, and who demonstrated care and concern for the other children in the group. Though his speech development has been slow, with his mastering at best a 3 word sentence, Mickey's play has become creative, resourceful, and reflective of his increasing curiosity in happenings around him as he has come out of his shell and become an appealing and warmly responsive little boy. His social and intellectual development, however, is still lagging.

After 2 years and 3 months of the Therapeutic Nursery School, Mickey was accepted into the special education program for M.R. children in the Public Schools. We are maintaining a close liason with the school and once weekly after-school sessions for Mickey and his mother to help with the transition.

Breaking all tradition in our Public Schools, Mrs. C. volunteered and was accepted into the classroom along with Mickey and works there with him on a part-time basis. Needless to say, her sophisticated skills are an asset

to the teacher struggling to provide an appropriate environment for Mickey as well as the other children. According to her own detailed reports, Mrs. C. is demonstrating remarkable sensitivity to the process issues in consultation in her interaction with the teacher.

A common thread occuring in these cases was that we had to mother the mothers, providing for them a corrective object relationship to make up for their own inadequate mothering--so that they could become more capable consequently of adequately mothering their own children. We watched the mothers grow in social and emotional maturity. They became more likeable people, and to our surprise and delight, they also became physically more attractive.

The three cases selected for presentation today represent significant degrees of emotional disturbances related to high degrees of emotional deprivation, early object relationships with varying degrees of active destructiveness, rather primitive familial settings, and with at least functional retardation. Treatment in a psychotherapeutic nursery school setting was able to effect some positive (and we hope significant and valuable) changes in each child and family, although by no means a complete "cure". We have also dealt with less disturbed children in our program whose problems fall more in the realm of behavior disorders. These cases were handled in a shorter time span with the outcome more closely approximating criteria of normal development for expected age level. They were transferred to regular nursery school settings.

We continue to be impressed with an increasing awareness of the complexities of early development and particularly with the utility of early intervention in the mother child dyad--when this development has gone awry.